To view printable form click here: Prior Authorization Document for Hearing Aids

471-000-205 Form MC-9S, "Prior Authorization Document for Hearing Aids" and Completion Instructions

FORM MC-9S PRIOR AUTHORIZATION DOCUMENT FOR HEARING AIDS
Health and Human Services System Finance and Support

1. Client Medicaid Number		
Client Name		
2. Hearing Aid Dispenser Medicaid Provider Number		
Business Name		
Street		
City	State	Zip Code
Phone Number		

Authorization Number

Form MC-9S is used to authorize hearing aids (471 NAC 8-000). Copy this form for office use. Incomplete forms will be returned.

The hearing aid provider shall complete fields 1 - 5, attach a completed DM-5H to Form MC-9S and forward to the Medicaid Division for review. (See 471-000-205 for completion instructions).

3. SERVICES TO BE AUTHORIZED

	CODE	MODIFIER	DESCRIPTION OF SERVICE	AMOUNT
a.		—		
b.		—		
c.		—		
d.		—		

4. Physician Name (From DM-5H) Physician License Number

5. ICD-9-CM Diagnosis Code

6. Additional Information

Denials may be appealed in writing within 90 days of the denial date by addressing a letter to the Director of Health and Human Services Finance & Support requesting a hearing and stating the basis for appeal.

7. Date Request Received

8. **I certify that the listed goods or services are authorized under the rules and regulations of the Nebraska Department of Health and Human Services, Finance and Support. The Department is not responsible for lost, stolen, or damaged rental items.**

NOTE: This authorization is void if the client is ineligible for Nebraska Medicaid or is enrolled in Nebraska Health Connection (NHC), the Medicaid Managed Care Program, at the time the service is provided. It is the responsibility of the provider to verify client Medicaid eligibility.

Medicaid Division

Central Office | Signature of Authorizing Agent | Date

Form MC-9S Instructions for Completion

Use: Form MC-9S is used to prior authorize payment for hearing aids as required by the Nebraska Medicaid Program (471 NAC 8-000). Copy this form for office use. Incomplete forms will be returned.

Prior authorization may also be requested and issued using the standard electronic Health Care Services Review - Request fo Review and Response transaction (ASC X 12N 278). For instructions, see 471-000-50 Standard Electronic Transactions.

Completion: Providers shall complete Form MC-9S as follows:

1. **CLIENT MEDICAID NUMBER:** Enter the client's eleven-digit Nebraska Medicaid identification number. **CLIENT NAME:** Enter the client's full name.
2. **HEARING AID DISPENSER MEDICAID PROVIDER NUMBER:** Enter the eleven-digit Nebraska Medicaid provider number of the hearing aid dispenser.
   BUSINESS NAME AND ADDRESS: Enter the hearing aid dispenser's business name, street address, city, state and zip code. The authorization will be returned to the business name and address listed.
   PHONE NUMBER: Enter the phone number at which the person requesting authorization may be contacted.
3. **SERVICES TO BE AUTHORIZED:** A maximum of four servies can be requested on each prior authorization request. For each item or service requested, enter the information listed below:

   Code: Enter the procedure code. See 471-000-508 for procedure codes used by Nebraska Medicaid.

   Modifier: Enter the procedure code modifier, if applicable.

   Description of Service: Enter the description of the item requested.

   Amount: Enter "IC" for items paid at invoice cost. Enter the dispenser's charge for other items requested.
4. **PHYSICIAN NAME:** Enter the name of the physician that signed the DM-5H, "Physician's Report on Hearing Loss".
   PHYSICIAN LICENSE NUMBER: Enter the license number of the physician that signed Form DM-5H. License number listings are available from HHS.
5. **ICD-9-CM DIAGNOSIS CODE:** Enter "3899".

6. ADDITIONAL INFORMATION: Use this section to provide additional information, if necessary. Do not complete Fields 7 and 8. These sections will be completed by Medicaid Division staff.

Distribution: The hearing aid dealer attaches the completed Form DM-5H, "Physician's Report on Hearing Loss" to the completed Form MC-9S and submits to: Health and Human Services Finance & Support, Medicaid Division, P.O. Box 95026, Lincoln, NE 68509-5026.

If the services are authorized, Medicaid Division staff will sign and date Form MC-9S and return one copy to the hearing aid dispenser.

If the services are denied, Medicaid Division staff will note the denial on Form MC-9S and return one copy to the hearing aid dispenser. Denials may be appeal in writing within 90 days of the denial date by addressing a letter to the Director of Health and Human Services Finance & Support requesting a hearing and stating the basis for appeal.